STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	10/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: October 15, 16, 17, and 18, 2012 Facility number: 001156 Provider number: 155505 AIM number: 100453350 Survey team: Janet Stanton, R.N.--Team Coordinator Michelle Hosteter, R.N. Michelle Carter, R.N. Heather Lay, R.N. (10/15, 16, 17) Census bed type: SNF--12 SNF/NF--62 Total--74 Census payor type: Medicare--10 Medicaid--44 Other--20 Total--74 Sample: 15 Supplemental sample: 2 These deficiencies reflect state findings cited in accordance with 410	F0000	I have enclosed the Plan of Correction for the above-referenced facility in response to the Statement of Deficiencies. While this document is being submitted as confirmation of the facility's on-going efforts to comply with all statutory and regulatory requirements, it should not be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or findings, nor have we identified mitigating factors. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a Post Survey Review on or after November 17, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	IAC 16.2. Quality review 10/26/12 by Suzanne Williams, RN			

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F0156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the			

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	individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.			
	Based on observation and interview, the facility failed to ensure information regarding Medicare, Medicaid, and contacting advocacy agencies was readily accessible to the residents of a locked dementia unit. This deficient practice affected 22 of 74 residents who resided on the locked dementia unit. Findings include: On 10/16/12 at 9:15 A.M., observation was made in the locked dementia unit. Information regarding Medicare, Medicaid, and how to contact advocacy agencies was not located. On 10/16/12 at 9:20 A.M., in an interview, the Memory Care Facilitator indicated the above information was	F0156	**F156 Notice of Rights, Rules, Services, and Charges** It is the practice of the provider to ensure that alleged violations involving the notice of rights, rules, services, and charges are in accordance with State and Federal Law. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The community notified residents and their responsible parties on this unit regarding Medicare, Medicaid, and contacting advocacy agencies. This information is now readily accessible to the residents on the secured Clare Bridge Dementia Unit. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will**	11/17/2012

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	posted in the health care center. In addition, the Memory Care Facilitator indicated family who visit have access to the information; however, unless residents are escorted out of the locked unit, they do not have access to the information. On 10/16/12 at 2:00 P.M., in an interview, the Executive Director indicated the facility would post the above information in the locked dementia unit. 3.1-3(b)(1)		**be taken:** The community notified residents and their responsible parties on this unit regarding Medicare, Medicaid, and contacting advocacy agencies. This information is now readily accessible to the residents on the secured Clare Bridge Dementia Unit. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Medicare, Medicaid, and contacting advocacy agencies information was posted in plain sight of the residents on the secured Clare Bridge Dementia Unit. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Medicare, Medicaid, and contacting advocacy agency information Quality Assurance Performance Improvement audit tool was developed and will be completed once weekly times 4 weeks, then bi-weekly times 4 weeks, and then quarterly thereafter until the alleged deficient practice does not recur.	

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to ensure physicians were notified regarding a change in condition for Residents #26, #30 and #40. The deficiency	F0157	**F157 Notify of Changes** It is the practice of this provider to ensure that the Notification of Changes, (Injury/Decline/Room) is in accordance with State and	11/17/2012

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	affected 3 of 3 residents reviewed for physician notification in a sample of 15. Findings include: 1. The clinical record for Resident #30 was reviewed on 10/16/12 at 12:45 P.M. Diagnoses for Resident #30 included, but were not limited to, thrombocytopenia, high blood pressure, insomnia, macular degeneration, dysphagia, and muscle weakness. Nursing notes, dated 9/01/12 at 11:00 A.M., indicated, "Resident's bilat (bilateral) edema has gotten worse, laid her down in bed to elevate her legs....also c/o (complains of) pain in legs. Both legs are very tight. + (plus sign) pitting edema....will continue to monitor her legs...." A document titled "Weekly Skin Integrity Review," with an entry dated 9/01/12, indicated "edema bilat (bilateral) legs." On 9/28/12 at 11:00 A.M., nursing notes indicated, "Left foot, 2nd (second) toe very red....tender- + (plus sign) edema whole foot, +3 to		Federal law through established procedures. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #30 physician was notified on 9/11/12 and family was notified on 9/28/12. Resident #30 has edema per Physician and is being treated with Furosemide. Resident #40 physician and family were notified on 9/27/12 and order for Cipro was initiated. No further signs of infection for this resident. Resident #26 physician and family were notified on 9/13/2012 and resident was sent to the Hospital. No further signs or symptoms of unresponsiveness for this resident. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Licensed Nurses will be educated on assessment, notification of physician and family, and documentation of changes in	

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	+4 edema- call to Dr. (physician name) - Keflex order." Nursing notes, dated 9/28/12 at 9:40 P.M., indicated, "Res (resident) is on ATB (antibiotic) for cellulitis at left foot 2nd (second) toe....." At the daily conference, on 10/16/12, this issue was discussed with the Administrator, Director of Nursing, and RN #1. As of the exit, on 10/18/12, no information related to notifying the physician related to the 9/01/12 documentation of Resident #30's increased bilateral edema to the lower extremities was presented. 2. The clinical record for Resident #40 was reviewed on 10/15/12 at 1:00 P.M. Diagnoses for Resident #40 included, but were not limited to, osteoporosis, macular degeneration, high blood pressure, atrial fibrillation, chronic heart failure, dysphagia, history of cerebral vascular accident with aphasia, chronic anxiety, left sided pleural effusion, gastroesophageal reflux disorder, failure to thrive and S/P (status post) gastrostomy. Nursing notes on 9/07/12 indicated, "Area around G-tube (gastrostomy		condition as well as use of the clinical status change log by the Director of Nursing or designee. In addition Licensed Nurses will be educated on care of gastrostomy tubes. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Director of Nursing or designee will audit the clinical status change log daily to ensure proper change of condition notification occurs for physician and family. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** All Clinical status changes will be reviewed weekly at the Quality of Care Meeting by the Interdisciplinary Team. The status of compliance with the clinical status change logs will be reviewed in the monthly Quality Assurance Performance Improvement meeting. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	

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	tube) site drsg (dressing) when changed has lg. (large) amt. (amount) of greenish slimmy (sic) odorous drainage noted. Passed on to day nurse." During an interview with RN #1, on 10/16/12 at 1:05 P.M., she stated "The communication between the night shift nurse and the day shift nurse, on 9/07/12, was not clear. The day shift nurse told her (RN #1) he was not aware of a possible infection around Resident #40's G-tube (gastrostomy tube) site, on 9/07/12." RN #1 indicated there was a lack in communication between the nurses that resulted in the physician not being notified of a change in condition. Physician orders, dated 9/27/12, indicated an antibiotic was ordered, Cipro 250 mg. (milligrams), crush tablet and sprinkle around G-tube site, daily for 7 days. On 9/28/12 at 9:45 A.M., nursing notes further indicated, "Res. (resident) is on ATB (antibiotic) for GI (gastrointestinal) site infection....." A facility policy, dated 4/1/2011, titled "Clinical Status Change", provided by Administration on 10/18/12 at 9:00			

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	A.M., included, but was not limited to, the following: Policy Overview; "When a resident is assessed as having a clinical status change, the licensed nurse will follow through in documenting notification to family/responsible party, the physician and other licensed nurses in order to facilitate the appropriate plan of care." Listed under "Significant clinical status changes may include, but are not limited to:" were mental status changes, complaint of new or unrelieved pain, change in skin condition, color and/or integrity, new onset edema, and infection/antibiotic therapy/isolation. 3. The clinical record review for Resident #26 was completed on 10/16/12 at 1 P.M. Diagnoses included, but were not limited to, end-stage dementia, aphasia/dysphagia. The nurses notes indicated that on 9/13/12 "call to room secondary to 'not right'-no appetite -responsive to staff-eyes fixed pupils-not following movement-non-reflexive-somelent (sic)-no change while in Dining Room-just stopped eating-food feel out of mouth-normally eats 100%" There was no indication in the nurses notes the physician was notified.			

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	In an interview during the daily conference on 10/18/12 at 1 P.M., RN #13 indicated they could not find any documentation regarding physician notification. 3.1-5(a)(2)			

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F0167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. Based on observation and interview, the facility failed to ensure survey results were readily accessible to the residents of a locked dementia unit. This deficient practice affected 22 of 74 residents who resided on the locked dementia unit. Findings include: On 10/16/12 at 9:15 A.M., observation was made in the locked dementia unit that the unit failed to have the facility's survey results readily accessible to the residents or have a sign posted where the results could be found. On 10/16/12 at 9:20 A.M., in an interview, the Memory Care Facilitator indicated the survey book and notice were located in the front lobby. In addition, the Memory Care Facilitator indicated family who visit have access	F0167	**F167 Right to Survey Results-Readily Accessible** It is the practice of this provider to ensure a resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The community notified residents and their responsible parties on this unit notifying them that the most recent survey of the facility as conducted by Federal or State surveyors will be readily accessible to residents and visitors on the secured Clare Bridge Dementia Unit.	11/17/2012

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	to the survey results; however, unless residents are escorted out of the locked unit, they do not have access to the survey results. 3.1-3(b)(1)		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The community notified residents and their responsible parties on this unit notifying them that the most recent survey of the facility as conducted by Federal or State surveyors will be readily accessible to residents and visitors on the secured Clare Bridge Dementia Unit. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A survey book was prepared which includes results of surveys conducted by Federal or State surveyors. This survey book will be located at the nurse's station in the secured Clare Bridge Dementia Unit. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**	

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			A survey book Quality Assurance Performance Improvement audit tool was developed and will be completed once weekly times 4 weeks, then bi-weekly times 4 weeks, and then quarterly thereafter until the alleged deficient practice does not recur. Results of the Quality Assurance Performance Improvement audits will be communicated to the Quality Assurance Performance Improvement Team.	

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F0223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure residents were free from abuse by facility staff. This deficient practice affected 2 of 2 residents [Residents #101 and 102] reviewed for allegations of abuse in a sample of 15 residents reviewed and 1 of 2 supplemental residents reviewed for allegations of abuse in a supplemental sample of 2 residents reviewed. [Resident #100] Findings include: 1. On 10/16/12 at 10:15 A.M., Resident #102's record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II, hypertension, and acute renal failure. Resident #102 was discharged from the facility on 10/12/12. An "Admission Evaluation Data" nursing assessment, dated 8/9/12,	F0223	**F223 Free From Abuse/Involuntary Seclusion** It is the practice of this provider to ensure that alleged violations involving Free from Abuse/Involuntary Seclusion are in accordance with State and Federal law. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #100, #101, and #102 have been discharged from the community. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**	11/17/2012

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	155505	A. BUILDING 00 B. WING	10/18/2012

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	indicated Resident #102 was alert to self. A "Social Service Progress Note" dated 8/16/12, included, but was not limited to, "Resident is alert and oriented to person. Resident requires assistance with ADL's [activities of daily living]... She is able to respond to direct communication... pleasant and cooperative with care..." On 10/16/12 at 2:30 A.M., the Executive Director provided the facility investigation for an allegation of abuse on 8/17/12 at 7:20 A.M. The abuse investigation included, but was not limited to, the following: "Indiana State Department of Health: Incident Report Form: Incident Date: 8/17/12 at 7:20 A.M.... Resident's Name: [Resident #102]... Staff Involved: [Certified Nursing Assistant] CNA #4... Brief Description of Incident: The CNA [#4] was observed by the charge nurse [Licensed Practical Nurse #6] standing looking at the resident with her arms folded saying 'I'm disappointed in you. I can't believe you did this.' The resident had just had a bowel movement. This resident is incontinent... Immediate Action: The		Staff will be re-educated regarding abuse and ensuring that residents are free from abuse. The Director of Nursing and the Executive Director will educate staff on the appropriate procedures of abuse investigations, including reporting allegations of abuse immediately. The community will continue to suspend associates whom have had an allegation of abuse made against them, and will continue to thoroughly investigate and document their investigations of allegations of abuse. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An abuse Quality Assurance Performance Improvement audit tool will be completed once weekly times 4 weeks, then bi-weekly times 4 weeks, then quarterly until the alleged deficient practice does not recur. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**	

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	CNA [#4] was removed from the room... Preventive Measures Taken: CNA [#4] was advised by the charge nurse [LPN #6] that we do not talk to residents in a scolding manner..." A written narrative, dated 8/17/12 at 1:30 P.M., included, but was not limited to, "Interview: [LPN #6]... [LPN #6] states he witnessed [CNA #4] standing in [Resident #102's] room with her arms crossed stating, 'I am disappointed in you, I can't believe you did that.' [LPN #6] stated that [Resident #102] looked upset and finally asked [CNA #4] why [CNA #4 was upset with her]... [CNA #4] then said I am just joking... [LPN #6] stated that [Resident #102] had just had a bowel movement... [LPN #6] stated that he went to [Resident #102] and stated you have done nothing wrong, you are fine... [LPN #6] stated that he felt [Resident #102] was upset... [LPN #6] stated that [Resident #102] cannot verbalize due to her CVA [cerebral vascular accident]. [LPN #6] advised the CNA [#4] we don't talk to residents in that manner..." A written narrative, dated 8/17/12 at 2:05 P.M., included, but was not limited to, "Interview: [CNA #4]... [CNA #4] was asked if she had any conversation with [Resident #102] this		The abuse Quality Assurance Performance Improvement audit tool will be reviewed in the monthly Quality Assurance Performance Improvement meeting by the Quality Assurance Committee. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible associate. 11/17/12	

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	morning between 7:15 A.M. to 8:00 A.M. [CNA #4] stated that she said to [Resident #102] I'm disappointed in you as a joke. [Resident #102] said why? [CNA #4] stated because you unbuttoned your shirt. [CNA #4] stated that's all she said to her..." A written narrative, dated 8/17/12 at 3:30 P.M., included, but was not limited to, "Interview: [Resident #102]... The Administrator and Speech Therapy interviewed [Resident #102] due to her CVA she would not communicate about the alleged events..." 2. On 10/16/12 at 10:45 A.M., Resident #101's record was reviewed. Diagnoses included, but were not limited to, anxiety and hypertension. Resident #101 was discharged home on 8/17/12. An "Admission Assessment Data" nursing notes, dated 7/30/12, included, but was not limited to, "Oriented to person, place, and time..." On 10/16/12 at 2:30 P.M., the Executive Director provided the facility investigation in regard to an allegation of verbal abuse that			

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	involved Resident #102 and CNA #4 on 8/17/12 at 7:45 A.M. The facility investigation included the following: "Indiana State Department of Health: Incident Report Form: Incident Date: 8/17/12 at 7:45 A.M.... Resident Name: [Resident #101]... Staff Name: [CNA #4]... Brief Description of Incident: CNA [#4] was overheard by another CNA [#7] arguing with a resident [Resident #101]... The CNA [#7] went to [Resident #101's] room and asked what was wrong. [Resident #101] stated she [CNA #4] won't let me do my own care, she snatches everything away from me and won't let me do it myself... Immediate Action Taken: The CNA [#4] was suspended when the Administrator was informed [facility unable to verify the time]... Preventive Measures Taken: The CNA [#4] was suspended..." A written statement, dated 8/17/12 at 1:55 P.M., included, but was not limited to, "Interview: [CNA #7]... states she was in room taking care of a resident when she heard [CNA #4] and [Resident #101] yelling at each other... [Resident #101] stated let me do this myself, meaning her ADL			

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	care... [CNA #4] stated no you can't... [Resident #101] looked at [CNA #7] and stated [CNA #4] just snatched all my stuff away and won't let me do it myself.... [Resident #101] stated I just want to do it myself... she then pointed at [CNA #4] and stated she never lets me do it myself... [CNA #4] left the room..." A written narrative, dated 8/17/12 at 2:05 P.M., included, but was not limited to, "Interview: [CNA #4]... stated she helps [Resident #101] to the bathroom and when she gets her there she doesn't want her to stay and help... [CNA #4] states the resident always says don't yell at me and don't push me... [Resident #101] is always angry in the morning and then she calms down through out the day..." A written narrative, dated 8/17/12 at 3:30 P.M., included, but was not limited to, "Interview: [Resident #106, Resident #101's roommate]... states she didn't hear a lot... I do know the girl [CNA #4] was exasperated with my roommate because she takes so long to do things... She [CNA #4] had to be forceful to get her to move..." A written narrative, dated 8/17/12 at 4:20 P.M., included, but was not			

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	limited to, "Interview: [Resident #101]... stated that [CNA #4] came in her room this morning and said you are going in the bathroom this morning now and get out so [Resident #106] can get in the bathroom... once she got on the toilet [CNA #4] jerked her gown off and told her to hurry up and get out... she stated that [CNA #4] would tell other CNA's that she always gets up angry... [Resident #101] stated it really hurt her feelings that she told everyone what I did wrong..." 3. On 10/16/12 at 11:00 A.M., Resident #100's record was reviewed. Diagnoses included, but were not limited to, pressure ulcer. Resident #100 was discharged from the facility on 7/12/12. A "Daily Skilled Nurse's Note" dated 6/11/12, no time, included, but was not limited to, "Cognitive: Alert and oriented to time and situation..." A "Brief Interview Mental Status" completed on 6/14/12 indicated a score of 15 [cognitively intact]. A "Social Service Progress Notes" dated 6/13/12, no time, included, but was not limited to, "Resident			

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	expressed a concern regarding a care giver that resulted in an allegation that will be investigated by the Administrator and nursing staff..." On 10/16/12 at 2:30 P.M., the Executive Director provided the facility investigation in regard to the allegation of physical abuse that involved Resident #100 and CNA #5 on 8/17/12 at 7:45 A.M. The facility investigation included the following: "Indiana State Department of Health: Incident Report Form: Resident Name: [Resident #100]... Staff Involved: [CNA #5]... Brief Description of Incident: The resident stated to one of our restorative nurse aides [RNA #8], on 6/13/12... [Resident #100] alleges that on 6/11 and 6/12 that [CNA #5] is rough with her and speaks rudely to her... Immediate Action Taken: [CNA #5] suspended the day the facility was notified of the incident, family notified, and physician notified... Preventive Measures Taken: All staff will be re-educated on abuse as of 6/20/12..." A written statement, dated 6/13/12 at 7:41 A.M., included, but was not			

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	limited to, "From [Director of Nursing at the time of the incident who no longer works at the facility]... I just spent a long time speaking with [Resident #100]... she is very upset with [CNA #5]... Actually in her own words afraid of her [CNA #5]... [Resident #100] was in tears... she didn't want to discuss this but [RNA #8] brought her to my office and she relayed her concerns... She [CNA #5] throws things at me when I ask for them... As you recall, [CNA #5] also had a situation with [another resident, who was no longer a resident at the facility] and can no longer care for him... She [CNA #5] change assignments... My concern is [Resident #100 and the other resident] are not the only residents she is doing this to... It broke my heart to see [Resident #100] so upset..." A written statement, dated 6/15/12 at 2:10 P.M., included, but was not limited to, "From [Director of Nursing at the time of the incident who no longer works at the facility]... Just had my conversation with [Resident #29, Resident #100's roommate at the time of the incident]... [Resident #29] confirms she heard [CNA #5] get frustrated with [Resident #100] because [Resident #100] is particular			

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	with what she wants..." A written statement, no date or time and no documentation of who wrote it, included, but was not limited to, "Conversation with [Resident #100] regarding events of last night... This morning [Resident #100] came to my office accompanied by RNA #8... she became very upset... she needed to report a situation that has occurred overnight... [CNA #5] pulled my sweater right off and messed up my hair... she just throws things around... she's always rough with me... she pushes and shoves me around... she throws me on the bed and where I land is where I have to stay... she rolls me over and she's really rough... she treats me badly... I don't want her to be my aide tonight... I'm really afraid of her..." CNA #5 was terminated from the facility on 6/18/12. On 10/17/12 at 11:00 A.M., in an interview, the Executive Director indicated the facility did not have any further documentation to provide for the abuse investigation that involved the allegation of verbal and physical abuse with Resident #100 by CNA #5. However, he indicated that CNA #5 was terminated related to the			

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	incident. 3.1-27(a)(1) 3.1-27(b)			

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F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and	F0225	**F225 Investigative/Report**	11/17/2012

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	interview, the facility failed to report an allegation of alleged abuse immediately to the facility Administrator, during an abuse investigation, the alleged violator was not suspended from work, and the facility failed to complete a thorough investigation. This deficient practice affected 2 of 2 residents [Residents #101 and 102] reviewed for allegations of abuse in a sample of 15 residents reviewed and 1 of 2 supplemental residents reviewed for allegations of abuse in a supplemental sample of 2 residents reviewed. [Resident #100] Findings include: 1. On 10/16/12 at 10:15 A.M., Resident #102's record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II, hypertension, and acute renal failure. Resident #102 was discharged from the facility on 10/12/12. An "Admission Evaluation Data" nursing assessment, dated 8/9/12, indicated Resident #102 was alert to self. A "Social Service Progress Note" dated 8/16/12, included, but was not		**Allegations/Individuals** It is the practice of this provider to not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property in accordance with State and Federal Law. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents #100, #101, and #102 were discharged from the community. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Staff will be educated regarding abuse and abuse reporting by the Director of Nursing and the Executive Director. The Director of Nursing and the Executive Director will re-educate staff on the appropriate	

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	limited to, "Resident is alert and oriented to person. Resident requires assistance with ADL's [activities of daily living]... She is able to respond to direct communication... pleasant and cooperative with care..." On 10/16/12 at 2:30 A.M., the Executive Director provided the facility investigation for an allegation of abuse on 8/17/12 at 7:20 A.M. The abuse investigation included, but was not limited to, the following: "Indiana State Department of Health: Incident Report Form: Incident Date: 8/17/12 at 7:20 A.M.... Resident's Name: [Resident #102]... Staff Involved: [Certified Nursing Assistant] CNA #4... Brief Description of Incident: The CNA [#4] was observed by the charge nurse [Licensed Practical Nurse #6] standing looking at the resident with her arms folded saying 'I'm disappointed in you. I can't believe you did this.' The resident had just had a bowel movement. This resident is incontinent... Immediate Action: The CNA [#4] was removed from the room... Preventive Measures Taken: CNA [#4] was advised by the charge nurse [LPN #6] that we do not talk to residents in a scolding manner..."		procedures of abuse investigations, including reporting allegations of abuse immediately. The community will continue to suspend associates whom have had an allegation of abuse made against them, and will continue to thoroughly investigate and document investigations of allegations of abuse. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An abuse Quality Assurance Performance Improvement audit tool will be completed once weekly times 4 weeks, then bi-weekly times 4 weeks, then quarterly until the alleged deficient practice does not recur. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The abuse Quality Assurance Performance Improvement audit tool will be reviewed in the monthly Quality Assurance Performance Improvement meeting by the Quality Assurance Committee.	

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	A written narrative, dated 8/17/12 at 1:30 P.M., included, but was not limited to, "Interview: [LPN #6]... [LPN #6] states he witnessed [CNA #4] standing in [Resident #102's] room with her arms crossed stating, 'I am disappointed in you, I can't believe you did that.' [LPN #6] stated that [Resident #102] looked upset and finally asked [CNA #4] why [CNA #4 was upset with her]... [CNA #4] then said I am just joking... [LPN #6] stated that [Resident #102] had just had a bowel movement... [LPN #6] stated that he went to [Resident #102] and stated you have done nothing wrong, you are fine... [LPN #6] stated that he felt [Resident #102] was upset... [LPN #6] stated that [Resident #102] cannot verbalize due to her CVA [cerebral vascular accident]. [LPN #6] advised the CNA [#4] we don't talk to residents in that manner..." The written narrative was not signed or did not indicate who it was written by. A written narrative, dated 8/17/12 at 2:05 P.M., included, but was not limited to, "Interview: [CNA #4]... [CNA #4] was asked if she had any conversation with [Resident #102] this morning between 7:15 A.M. to 8:00		Deficiency in this practice will result in disciplinary action up to and including termination of the responsible associate. 11/17/2012	

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	A.M. [CNA #4] stated that she said to [Resident #102] I'm disappointed in you as a joke. [Resident #102] said why? [CNA #4] stated because you unbuttoned your shirt. [CNA #4] stated that's all she said to her..." The written narrative was not signed or did not indicate who it was written by. A written narrative, dated 8/17/12 at 3:30 P.M., included, but was not limited to, "Interview: [Resident #102]... The Administrator and Speech Therapy interviewed [Resident #102] due to her CVA she would not communicate about the alleged events..." There was no other documentation in the facility investigation of the abuse allegation. In addition, there was no documentation located in Resident #102's closed clinical record. On 10/17/12 at 9:00 A.M., the Executive Director provided the facility's schedule as worked, dated 8/17/12. The schedule included the name of CNA #4 as having worked the 1st shift [6 A.M. to 2 P.M.] on 8/17/12. There was no documentation of CNA			

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	#4 leaving the facility before her scheduled shift ended on 8/17/12. On 10/17/12 at 11:00 A.M., in an interview, the Executive Director indicated the facility did not have any further documentation to provide for the abuse investigation that involved the allegation of verbal abuse with Resident #102 by CNA #4. In addition, the Executive Director indicated that since he was not present as the Executive Director, he could not verify when the Administrator, at that time, was notified of the incident, if CNA #4 was suspended immediately, or if a more thorough investigation was completed. 2. On 10/16/12 at 10:45 A.M., Resident #101's record was reviewed. Diagnoses included, but were not limited to, anxiety and hypertension. Resident #101 was discharged home on 8/17/12. An "Admission Assessment Data" nursing notes, dated 7/30/12, included, but was not limited to, "Oriented to person, place, and time..."			

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	On 10/16/12 at 2:30 P.M., the Executive Director provided the facility investigation in regard to an allegation of verbal abuse that involved Resident #102 and CNA #4 on 8/17/12 at 7:45 A.M. The facility investigation included the following: "Indiana State Department of Health: Incident Report Form: Incident Date: 8/17/12 at 7:45 A.M.... Resident Name: [Resident #101]... Staff Name: [CNA #4]... Brief Description of Incident: CNA [#4] was overheard by another CNA [#7] arguing with a resident [Resident #101]... The CNA [#7] went to [Resident #101's] room and asked what was wrong. [Resident #101] stated she [CNA #4] won't let me do my own care, she snatches everything away from me and won't let me do it myself... Immediate Action Taken: The CNA [#4] was suspended when the Administrator was informed [facility unable to verify the time]... Preventive Measures Taken: The CNA [#4] was suspended..." A written statement, dated 8/17/12 at 1:55 P.M., included, but was not limited to, "Interview: [CNA #7]... states she was in room taking care of			

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	a resident when she heard [CNA #4] and [Resident #101] yelling at each other... [Resident #101] stated let me do this myself, meaning her ADL care... [CNA #4] stated no you can't... [Resident #101] looked at [CNA #7] and stated [CNA #4] just snatched all my stuff away and won't let me do it myself.... [Resident #101] stated I just want to do it myself... she then pointed at [CNA #4] and stated she never lets me do it myself... [CNA #4] left the room..." A written narrative, dated 8/17/12 at 2:05 P.M., included, but was not limited to, "Interview: [CNA #4]... stated she helps [Resident #101] to the bathroom and when she gets her there she doesn't want her to stay and help... [CNA #4] states the resident always says don't yell at me and don't push me... [Resident #101] is always angry in the morning and then she calms down through out the day..." A written narrative, dated 8/17/12 at 3:30 P.M., included, but was not limited to, "Interview: [Resident #106, Resident #101's roommate]... states she didn't hear a lot... I do know the girl [CNA #4] was exasperated with my roommate because she takes so long to do things... She [CNA #4] had			

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	to be forceful to get her to move..." A written narrative, dated 8/17/12 at 4:20 P.M., included, but was not limited to, "Interview: [Resident #101]... stated that [CNA #4] came in her room this morning and said you are going in the bathroom this morning now and get out so [Resident #106] can get in the bathroom... once she got on the toilet [CNA #4] jerked her gown off and told her to hurry up and get out... she stated that [CNA #4] would tell other CNA's that she always gets up angry... [Resident #101] stated it really hurt her feelings that she told everyone what I did wrong..." There was no other documentation in the investigation or the resident's clinical record regarding the incident on 8/17/12 at 7:45 A.M. On 10/17/12 at 9:00 A.M., the Executive Director provided the facility's schedule as worked, dated 8/17/12. The schedule included the name of CNA #4 as having worked the 1st shift [6 A.M. to 2 P.M.] on 8/17/12. There was no documentation of CNA #4 leaving the facility before her scheduled shift ended on 8/17/12.			

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	On 10/17/12 at 11:00 A.M., in an interview, the Executive Director indicated the facility did not have any further documentation to provide for the abuse investigation that involved the allegation of verbal and physical abuse with Resident #101 by CNA #4. In addition, the Executive Director indicated that since he was not present as the Executive Director, he could not verify when the Administrator, at that time, was notified of the incident, if CNA #4 was suspended immediately, or if a more thorough investigation was completed. 3. On 10/16/12 at 11:00 A.M., Resident #100's record was reviewed. Diagnoses included, but were not limited to, pressure ulcer. Resident #100 was discharged from the facility on 7/12/12. A "Daily Skilled Nurse's Note" dated 6/11/12, no time, included, but was not limited to, "Cognitive: Alert and oriented to time and situation..." A "Brief Interview Mental Status" completed on 6/14/12 indicated a			

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	score of 15 [cognitively intact]. A "Social Service Progress Notes" dated 6/13/12, no time, included, but was not limited to, "Resident expressed a concern regarding a care giver that resulted in an allegation that will be investigated by the Administrator and nursing staff..." On 10/16/12 at 2:30 P.M., the Executive Director provided the facility investigation in regard to the allegation of physical abuse that involved Resident #100 and CNA #5 on 8/17/12 at 7:45 A.M. The facility investigation included the following: "Indiana State Department of Health: Incident Report Form: Resident Name: [Resident #100]... Staff Involved: [CNA #5]... Brief Description of Incident: The resident stated to one of our restorative nurse aides [RNA #8], on 6/13/12... [Resident #100] alleges that on 6/11 and 6/12 that [CNA #5] is rough with her and speaks rudely to her... Immediate Action Taken: [CNA #5] suspended the day the facility was notified of the incident, family notified, and physician notified... Preventive Measures Taken: All staff will be			

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	re-educated on abuse as of 6/20/12..." A written statement, dated 6/13/12 at 7:41 A.M., included, but was not limited to, "From [Director of Nursing at the time of the incident who no longer works at the facility]... I just spent a long time speaking with [Resident #100]... she is very upset with [CNA #5]... Actually in her own words afraid of her [CNA #5]... [Resident #100] was in tears... she didn't want to discuss this but [RNA #8] brought her to my office and she relayed her concerns... She [CNA #5] throws things at me when I ask for them... As you recall, [CNA #5] also had a situation with [another resident, who was no longer a resident at the facility] and can no longer care for him... She [CNA #5] change assignments... My concern is [Resident #100 and the other resident] are not the only residents she is doing this to... It broke my heart to see [Resident #100] so upset..." A written statement, dated 6/15/12 at 2:10 P.M., included, but was not limited to, "From [Director of Nursing at the time of the incident who no longer works at the facility]... Just had my conversation with [Resident #29,			

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	Resident #100's roommate at the time of the incident]... [Resident #29] confirms she heard [CNA #5] get frustrated with [Resident #100] because [Resident #100] is particular with what she wants..." A written statement, no date or time and no documentation of wrote it, included, but was not limited to, "Conversation with [Resident #100] regarding events of last night... This morning [Resident #100] came to my office accompanied by RNA #8... she became very upset... she needed to report a situation that has occurred overnight... [CNA #5] pulled my sweater right off and messed up my hair... she just throws things around... she's always rough with me... she pushes and shoves me around... she throws me on the bed and where I land is where I have to stay... she rolls me over and she's really rough... she treats me badly... I don't want her to be my aide tonight... I'm really afraid of her..." There was no other documentation regarding in the facility investigation in the resident's clinical record. On 10/17/12 at 9:00 A.M., the Executive Director provided the facility's schedule as worked, dated			

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	6/13/12. The schedule included the name of CNA #5 as having worked the 2nd shift [2 P.M. to 10 P.M.] on 6/13/12. CNA #5 was terminated from the facility on 6/18/12. On 10/17/12 at 11:00 A.M., in an interview, the Executive Director indicated the facility did not have any further documentation to provide for the abuse investigation that involved the allegation of verbal and physical abuse with Resident #100 by CNA #5. In addition, the Executive Director indicated that since he was not present as the Executive Director, he could not verify when the Administrator, at that time, was notified of the incident, if CNA #5 was suspended immediately, or if a more thorough investigation was completed. 3.1-28(c)			

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F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure their Abuse Prohibition Policies were followed related to reporting alleged abuse immediately to the Administrator, the facility failed to follow their policy related to protection of residents during an alleged abuse investigation as the alleged violator was not suspended from work, and failed to thoroughly investigate the allegations of abuse. The deficient practice impacted 2 of 2 residents [Residents #101 and 102] reviewed for allegations of abuse in a sample of 15 residents reviewed and 1 of 2 residents reviewed for allegations of abuse in a supplemental sample of 2 residents reviewed. [Resident #100] Findings include: 1. On 10/16/12 at 10:15 A.M., Resident #102's record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II, hypertension, and acute renal failure.	F0226	**F226 Develop/Implement Abuse/Neglect, Policies** It is the practice of this provider to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #100, #101, and #102 have been discharged from the community. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Staff will be educated regarding abuse and abuse reporting by the Director of Nursing and the	11/17/2012

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	Resident #102 was discharged from the facility on 10/12/12. An "Admission Evaluation Data" nursing assessment, dated 8/9/12, indicated Resident #102 was alert to self. A "Social Service Progress Note" dated 8/16/12, included, but was not limited to, "Resident is alert and oriented to person. Resident requires assistance with ADL's [activities of daily living]... She is able to respond to direct communication... pleasant and cooperative with care..." On 10/16/12 at 2:30 A.M., the Executive Director provided the facility investigation for an allegation of abuse on 8/17/12 at 7:20 A.M. The abuse investigation included, but was not limited to, the following: "Indiana State Department of Health: Incident Report Form: Incident Date: 8/17/12 at 7:20 A.M.... Resident's Name: [Resident #102]... Staff Involved: [Certified Nursing Assistant] CNA #4... Brief Description of Incident: The CNA [#4] was observed by the charge nurse [Licensed Practical Nurse #6] standing looking at the resident with her arms folded		Executive Director. The Director of Nursing and the Executive Director will re-educate staff on the appropriate procedures of abuse investigations, including reporting allegations of abuse immediately. The community will continue to suspend associates whom have had an allegation of abuse made against them, and will continue to thoroughly investigate and document investigations of allegations of abuse. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An abuse Quality Assurance Performance Improvement audit tool will be completed once weekly times 4 weeks, then bi-weekly times 4 weeks, then quarterly until the alleged deficient practice does not recur. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The abuse Quality Assurance Performance Improvement audit	

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	saying 'I'm disappointed in you. I can't believe you did this.' The resident had just had a bowel movement. This resident is incontinent... Immediate Action: The CNA [#4] was removed from the room... Preventive Measures Taken: CNA [#4] was advised by the charge nurse [LPN #6] that we do not talk to residents in a scolding manner..." A written narrative, dated 8/17/12 at 1:30 P.M., included, but was not limited to, "Interview: [LPN #6]... [LPN #6] states he witnessed [CNA #4] standing in [Resident #102's] room with her arms crossed stating, 'I am disappointed in you, I can't believe you did that.' [LPN #6] stated that [Resident #102] looked upset and finally asked [CNA #4] why [CNA #4 was upset with her]... [CNA #4] then said I am just joking... [LPN #6] stated that [Resident #102] had just had a bowel movement... [LPN #6] stated that he went to [Resident #102] and stated you have done nothing wrong, you are fine... [LPN #6] stated that he felt [Resident #102] was upset... [LPN #6] stated that [Resident #102] cannot verbalize due to her CVA [cerebral vascular accident]. [LPN #6] advised the CNA [#4] we don't talk to residents in that manner..."		tool will be reviewed in the monthly Quality Assurance Performance Improvement meeting by the Quality Assurance Committee. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible associate.	

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	The written narrative was not signed or did not indicate who it was written by. A written narrative, dated 8/17/12 at 2:05 P.M., included, but was not limited to, "Interview: [CNA #4]... [CNA #4] was asked if she had any conversation with [Resident #102] this morning between 7:15 A.M. to 8:00 A.M. [CNA #4] stated that she said to [Resident #102] I'm disappointed in you as a joke. [Resident #102] said why? [CNA #4] stated because you unbuttoned your shirt. [CNA #4] stated that's all she said to her..." The written narrative was not signed or did not indicate who it was written by. A written narrative, dated 8/17/12 at 3:30 P.M., included, but was not limited to, "Interview: [Resident #102]... The Administrator and Speech Therapy interviewed [Resident #102] due to her CVA she would not communicate about the alleged events..." There was no other documentation in the facility investigation of the abuse allegation. In addition, there was no documentation located in Resident #102's closed clinical record.			

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ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

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	On 10/17/12 at 9:00 A.M., the Executive Director provided the facility's schedule as worked, dated 8/17/12. The schedule included the name of CNA #4 as having worked the 1st shift [6 A.M. to 2 P.M.] on 8/17/12. There was no documentation of CNA #4 leaving the facility before her scheduled shift ended on 8/17/12. On 10/17/12 at 11:00 A.M., in an interview, the Executive Director indicated the facility did not have any further documentation to provide for the abuse investigation that involved the allegation of verbal abuse with Resident #102 by CNA #4. In addition, the Executive Director indicated that since he was not present as the Executive Director, he could not verify when the Administrator, at that time, was notified of the incident, if CNA #4 was suspended immediately, or if a more thorough investigation was completed. 2. On 10/16/12 at 10:45 A.M., Resident #101's record was reviewed. Diagnoses included, but were not limited to, anxiety and hypertension.			

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Resident #101 was discharged home on 8/17/12.

An "Admission Assessment Data" nursing notes, dated 7/30/12, included, but was not limited to, "Oriented to person, place, and time..."

On 10/16/12 at 2:30 P.M., the Executive Director provided the facility investigation in regard to an allegation of verbal abuse that involved Resident #102 and CNA #4 on 8/17/12 at 7:45 A.M.

The facility investigation included the following:

"Indiana State Department of Health: Incident Report Form: Incident Date: 8/17/12 at 7:45 A.M.... Resident Name: [Resident #101]... Staff Name: [CNA #4]... Brief Description of Incident: CNA [#4] was overheard by another CNA [#7] arguing with a resident [Resident #101]... The CNA [#7] went to [Resident #101's] room and asked what was wrong. [Resident #101] stated she [CNA #4] won't let me do my own care, she snatches everything away from me and won't let me do it myself... Immediate Action Taken: The CNA

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	[#4] was suspended when the Administrator was informed [facility unable to verify the time]... Preventive Measures Taken: The CNA [#4] was suspended..." A written statement, dated 8/17/12 at 1:55 P.M., included, but was not limited to, "Interview: [CNA #7]... states she was in room taking care of a resident when she heard [CNA #4] and [Resident #101] yelling at each other... [Resident #101] stated let me do this myself, meaning her ADL care... [CNA #4] stated no you can't... [Resident #101] looked at [CNA #7] and stated [CNA #4] just snatched all my stuff away and won't let me do it myself.... [Resident #101] stated I just want to do it myself... she then pointed at [CNA #4] and stated she never lets me do it myself... [CNA #4] left the room..." A written narrative, dated 8/17/12 at 2:05 P.M., included, but was not limited to, "Interview: [CNA #4]... stated she helps [Resident #101] to the bathroom and when she gets her there she doesn't want her to stay and help... [CNA #4] states the resident always says don't yell at me and don't push me... [Resident #101] is always angry in the morning and then she calms down through out the			

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	day..." A written narrative, dated 8/17/12 at 3:30 P.M., included, but was not limited to, "Interview: [Resident #106, Resident #101's roommate]... states she didn't hear a lot... I do know the girl [CNA #4] was exasperated with my roommate because she takes so long to do things... She [CNA #4] had to be forceful to get her to move..." A written narrative, dated 8/17/12 at 4:20 P.M., included, but was not limited to, "Interview: [Resident #101]... stated that [CNA #4] came in her room this morning and said you are going in the bathroom this morning now and get out so [Resident #106] can get in the bathroom... once she got on the toilet [CNA #4] jerked her gown off and told her to hurry up and get out... she stated that [CNA #4] would tell other CNA's that she always gets up angry... [Resident #101] stated it really hurt her feelings that she told everyone what I did wrong..." There was no other documentation in the investigation or the resident's clinical record regarding the incident on 8/17/12 at 7:45 A.M. On 10/17/12 at 9:00 A.M., the			

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	Executive Director provided the facility's schedule as worked, dated 8/17/12. The schedule included the name of CNA #4 as having worked the 1st shift [6 A.M. to 2 P.M.] on 8/17/12. There was no documentation of CNA #4 leaving the facility before her scheduled shift ended on 8/17/12. On 10/17/12 at 11:00 A.M., in an interview, the Executive Director indicated the facility did not have any further documentation to provide for the abuse investigation that involved the allegation of verbal and physical abuse with Resident #101 by CNA #4. In addition, the Executive Director indicated that since he was not present as the Executive Director, he could not verify when the Administrator, at that time, was notified of the incident, if CNA #4 was suspended immediately, or if a more thorough investigation was completed. 3. On 10/16/12 at 11:00 A.M., Resident #100's record was reviewed. Diagnoses included, but were not limited to, pressure ulcer.			

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	Resident #100 was discharged from the facility on 7/12/12. A "Daily Skilled Nurse's Note" dated 6/11/12, no time, included, but was not limited to, "Cognitive: Alert and oriented to time and situation..." A "Brief Interview Mental Status" completed on 6/14/12 indicated a score of 15 [cognitively intact]. A "Social Service Progress Notes" dated 6/13/12, no time, included, but was not limited to, "Resident expressed a concern regarding a care giver that resulted in an allegation that will be investigated by the Administrator and nursing staff..." On 10/16/12 at 2:30 P.M., the Executive Director provided the facility investigation in regard to the allegation of physical abuse that involved Resident #100 and CNA #5 on 8/17/12 at 7:45 A.M. The facility investigation included the following: "Indiana State Department of Health: Incident Report Form: Resident Name: [Resident #100]... Staff Involved: [CNA #5]... Brief Description of Incident: The resident			

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	stated to one of our restorative nurse aides [RNA #8], on 6/13/12... [Resident #100] alleges that on 6/11 and 6/12 that [CNA #5] is rough with her and speaks rudely to her... Immediate Action Taken: [CNA #5] suspended the day the facility was notified of the incident, family notified, and physician notified... Preventive Measures Taken: All staff will be re-educated on abuse as of 6/20/12..." A written statement, dated 6/13/12 at 7:41 A.M., included, but was not limited to, "From [Director of Nursing at the time of the incident who no longer works at the facility]... I just spent a long time speaking with [Resident #100]... she is very upset with [CNA #5]... Actually in her own words afraid of her [CNA #5]... [Resident #100] was in tears... she didn't want to discuss this but [RNA #8] brought her to my office and she relayed her concerns... She [CNA #5] throws things at me when I ask for them... As you recall, [CNA #5] also had a situation with [another resident, who was no longer a resident at the facility] and can no longer care for him... She [CNA #5] change assignments... My concern is [Resident #100 and the other resident] are not the only residents			

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she is doing this to... It broke my heart to see [Resident #100] so upset..."

A written statement, dated 6/15/12 at 2:10 P.M., included, but was not limited to, "From [Director of Nursing at the time of the incident who no longer works at the facility]... Just had my conversation with [Resident #29, Resident #100's roommate at the time of the incident]... [Resident #29] confirms she heard [CNA #5] get frustrated with [Resident #100] because [Resident #100] is particular with what she wants..."

A written statement, no date or time and no documentation of wrote it, included, but was not limited to, "Conversation with [Resident #100] regarding events of last night... This morning [Resident #100] came to my office accompanied by RNA #8... she became very upset... she needed to report a situation that has occurred overnight... [CNA #5] pulled my sweater right off and messed up my hair... she just throws things around... she's always rough with me... she pushes and shoves me around... she throws me on the bed and where I land is where I have to stay... she rolls me over and she's really rough... she treats me badly... I don't want her

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	to be my aide tonight... I'm really afraid of her..." There was no other documentation regarding in the facility investigation in the resident's clinical record. On 10/17/12 at 9:00 A.M., the Executive Director provided the facility's schedule as worked, dated 6/13/12. The schedule included the name of CNA #5 as having worked the 2nd shift [2 P.M. to 10 P.M.] on 6/13/12. CNA #5 was terminated from the facility on 6/18/12. On 10/17/12 at 11:00 A.M., in an interview, the Executive Director indicated the facility did not have any further documentation to provide for the abuse investigation that involved the allegation of verbal and physical abuse with Resident #100 by CNA #5. In addition, the Executive Director indicated that since he was not present as the Executive Director, he could not verify when the Administrator, at that time, was notified of the incident, if CNA #5 was suspended immediately, or if a more			

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	thorough investigation was completed. 3.1-28(a)			

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review, the facility failed to maintain the dignity of a resident while they were being fed during a meal. This affected 1 of 1 resident observed being fed during a meal observation in a sample of 15. (Resident #13) Findings include: The clinical record review for Resident #13 was completed on 10/17/12 at 3:15 P.M. Diagnoses included, but were not limited to, legal blindness, anxiety, and reflux disease. A meal observation was done on 10/15/12 at 1:20 P.M. in the main dining room. There was a group of residents sitting at a table. CNA #3 was observed standing over Resident #13. She stabbed the grilled cheese sandwich with a fork and gave the sandwich to Resident #13. CNA #3 also fed a brownie to the resident while she (the CNA) was standing	F0241	**F241 Dignity and Respect of Individuality** It is the practice of the provider to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Staff were re-educated on how to assist Resident #13 at meal times. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Staff will be re-educated on	11/17/2012

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	up. In an interview at the daily conference on 10/17/12 at 3:45 P.M., R.N. #13 indicated staff should not be standing up while feeding a resident. 3.1-3(t)		facility policy on assistance with meals by the Director of Nursing and Dietary Manager. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Staff were re-educated on facility policy on assistance with meals by the Director of Nursing and Dietary Manager to maintain resident dignity and respect during meal times. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** A dignity and respect Quality Assurance Performance Improvement audit tool will be utilized weekly times 4 weeks, then bi-weekly times 4 weeks and then monthly until the alleged deficient practice does not recur. The Quality Assurance Performance Improvement audits will be reviewed in the monthly Quality Assurance Performance Improvement meeting by the Quality Assurance committee.	

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F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). A. Based on interview and record review, the facility failed to develop individualized behavior interventions to use for 1 of 8 residents who were identified as having behaviors in a sample of 15 residents reviewed. [Resident #47] B. Based on interview and record review, the facility failed to ensure that a coordinated Care Plan was developed in conjunction between the facility and a Hospice agency, which clearly outlined the specific responsibilities and services to be	F0279	**F279 Develop Comprehensive Care Plans** It is the practice of the provider to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #47 had their care plan customized for resident specific	11/17/2012

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	provided by each; for 2 of 2 residents reviewed who were receiving Hospice services, in a sample of 15 residents. [Residents #26 and #63] Findings include: A.1. In an interview during the initial orientation tour on 10/15/12 at 11:05 A.M., L.P.N. #1 indicated Resident #47 had episodes of agitation, and would "throw things." The nurse indicated the resident was hard of hearing but refused to wear her hearing aid, and had episodes of refusing to eat or take a nutritional supplement. The clinical record for Resident #47 was reviewed on 10/15/12 at 1:00 P.M. On 10/14/10, the resident was re-admitted to the facility, to the locked/secured Alzheimer's unit, with diagnoses that included, but were not limited to, senile dementia--Alzheimer's type, symbolic dysfunction, dysphagia, severe chronic back due to spinal compression fractures, and pelvic joint pain. A quarterly M.D.S. [Minimum Data Set] assessment, dated 7/25/12, indicated the resident had adequate hearing, unclear speech, and required		interventions to address behaviors exhibited by resident. Care Plans will continue to be updated as needed depending on the behavior that was exhibited by resident. Resident #26 we implemented a combined care plan with facility and Hospice provider and created an interdisciplinary care plan with Hospice and Facility. Facility conducted a Care Plan on 11/7/12 in attendance was Facility staff and Hospice staff and resident #26 family. During care plan on 11/7/12 residents overall plan of care was reviewed. Multiple Data Set will have significant revisions with result to cause and care plans. Resident #63 we implemented a combined care plan with facility and Hospice provider and created an interdisciplinary care plan with Hospice and Facility. Facility conducted a meeting with the Hospice Provider on 10/18/12 to update residents care plan to address resident's individual needs. Family notified of updates to care plan and new orders and family agreed with updates. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**	

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	the physical assistance of 1-2 staff for all daily care. The assessment indicated the resident's BIMS [Brief Interview for Mental Status] score was "00" [0-7=severe cognitive impairment]. An activity "Interest Survey" form, dated 7/16/09, indicated the resident had been a professional secretary, liked lunch/dinner outings and birthday parties; enjoyed arts/crafts instruction and cooking demonstrations; had an interest in participating in worship services and prayer groups; and enjoyed music--country, classical, soul/blues, folk, holiday, and big bands. One Care Plan entry, dated 5/2/12 and updated 7/31/12, addressed a problem of "Resident has dementia with aggressive behaviors." The interventions were listed as: "Talk with resident during care; re-orient resident as needed; provide resident with cues, signs and reminders as needed for direction; praise resident for all efforts they make; encourage family to be supportive and active in resident's daily life; put up as much of resident's own things in their room such as pictures; encourage resident to attend activities and socialize with others; encourage diet/fluids; staff to		Care Plan Meetings will continue to be conducted for residents on Hospice. The Care Plan Meetings will include the Hospice Provider, the Facility and Family/Responsible Party within first 21-days of admission to the Hospice program. During the Care Plan Meeting the Care Plan will be reviewed and coordinated between Hospice Provider and the Facility. Facility will continue to address specific care needs, duties, and services to be provided to the hospice resident by Facility and Hospice Staff. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Care Plan team will meet with Hospice and Family within first 21-days of admission to the Hospice program to discuss Care Plan needs and services specific to the hospice resident and responsibilities for Facility Staff and Hospice Staff. Facility staff will be re-educated to what Hospice responsibilities are for the hospice resident and what the Facility responsibilities are for the hospice resident. **How the corrective action(s) will be monitored to ensure the**	

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	provide assist as resident needs with encourage resident to help as much as they can; provide a safe clutter free environment." Another Care Plan entry, with no start date listed, addressed a problem of "Behavioral Symptoms: [Resident's name] has physical behavioral symptoms directed at others." The interventions were listed as: "Provide medication as ordered; record behaviors on Behavior Tracking Form. Monitor pattern of behavior (time of day, precipitation factors, specific staff or situations); remind [resident's name] that BEHAVIOR is not appropriate; remove from situation, allow time to calm down." A third Care Plan entry, with no start date listed, addressed a problem of "Behavioral Symptoms: [Resident's name] has other behavioral symptoms not directed toward others." The interventions were listed as: "Gently remind [resident's name] that throwing objects is not appropriate; refer to psych [psychiatric] services as needed. Offer redirection at times of behavior; approach resident in a calm manner. Call resident by name. Assist with care needs; remove from situation, allow time to calm down."		**deficient practice will not recur, i.e., what quality assurance program will be put into place:** A Hospice and Facility role and responsibility Quality Assurance Performance Improvement audit tool will be completed 1 time weekly times 1 quarter, then 1 time bi-weekly for 1-month until the alleged deficient practice does not recur.	

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	In an interview on 10/15/12 at 11:45 A.M., L.P.N. #1 identified the "Behavior/Intervention Monthly Flow Record" forms as the system used to track the number of episodes of behaviors displayed by a resident. The June, July, August, and September, 2012 forms for Resident #47 listed the following targeted behaviors for monitoring: June--Increased anger; tantrum throwing; aggressive behaviors; hitting at staff. July--Increased anger; tantrum throwing; psychosis; hallucinating. August--Combative; verbal abuse; throwing things. September--Combative; inappropriate verbal statements; throwing things. The "Intervention Codes" key for each month, each targeted behavior, listed the same general and generic approaches: "Redirect; 1 on 1; refer to nurse's notes; activity; return to room; toilet; give food; give fluids; change position; adjust room temperature; backrub." There were no interventions added that were specific to this resident.			

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	During the daily conference on 10/17/12 at 4:15 P.M., the Executive Director and the interim Director of Nursing were given the opportunity to submit any documentation/evidence that interventions, individualized to utilize the resident's interests and preferences, were care-planned. At the final exit on 10/18/12 at 5:05 P.M., no additional documentation/evidence of individualized care planned interventions were provided for review. B.1. In an interview during the initial orientation tour on 10/15/12 at 11:40 A.M., L.P.N. #1 indicated Resident #63 used a staff-propelled "Broda" [specialized reclining wheelchair] for mobility, needed physical assistance from staff for all care, had contractures of his hands and one leg, was prescribed a puree diet due to swallowing problems, and had a history of falls requiring bed and chair alarms. The nurse indicated the resident was receiving services from a Hospice agency. The clinical record for Resident #63 was reviewed on 10/16/12 at 2:40 P.M. Diagnoses included, but were not limited to, senile dementia-			

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	-Alzheimer's type, depression, non-insulin dependent diabetes, chronic obstructive pulmonary disease, dysphagia, and coronary artery disease with history of heart attack. The resident was admitted to a Hospice service agency on 4/25/12. An "Interdisciplinary Care Plan Progress Notes" form, dated 8/8/12, indicated a quarterly Care Plan conference was held. The facility Social Service Director, the Dietary Manager, the Alzheimer's unit Facilitator, and the unit nurse signed the form as attendees. There were no signatures from any Hospice staff. A "Comment" note indicated "... He continues to receive Hospice care...." An "Interdisciplinary Care Plan Progress Notes" form, dated 9/10/12, indicated a Care Plan conference was held "per family request." Attendee signatures included two Hospice nursing staff.. A "Comments" note indicated "... Addressed questions related to current health condition and health status. Resident is currently having a concern with coughing during meals. Family does not want a G-tube [gastrostomy tube for nutrition]...."			

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	The facility Care Plan, with problem start dates of 3/12, 7/9, 8/7, and 9/11/12, addressed problem areas of dental care, incontinence of bladder and toileting, self care deficit, altered cardiac function, risk for falls, DNR [Do Not Resuscitate] status, diabetes and neuropathy pain, depression and aggressive behaviors, dementia and cognitive status, nutritional status and altered diet, and activity deficits. The interventions listed for each problem area were to be provided by facility staff. There were no interventions listed related to Hospice responsibilities and services to be provided by that agency. A facility Care Plan entry, dated 4/25 and updated 8/5/12, addressed a problem of "Resident on Hospice." The interventions, to be provided by facility staff, were listed as: "All staff will be made aware of resident being on hospice; staff will keep hospice personal [sic] informed of the residents condition and any changes; staff will encourage hospice staff to let them know the best way to care for resident if they are in need of anything different than they were receiving prior to hospice; family will be made aware that staff will be working with hospice and can assist			

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	them in any way with issues that they themselves might be dealing with and how that they as family members can assist the resident; residents current plan of care will continue to be used and updated as necessary." A coordinated list of specific responsibilities, duties, and services to be provided to the resident by facility and Hospice staff was not listed. The Hospice agency Care Plan, which was located in a separate binder at the Nurse's Station and dated 9/11 to 9/25/12, listed the services to be provided by the Hospice skilled nurse, social worker, and chaplain. Problem areas were listed as "Decisional capacity; Alteration in Comfort; Management of Terminal Condition; Home Health Aide Needed; Advance Directives; Alteration in Cardio-Pulmonary Function; Alteration in Nutritional Status; Risk for Skin Breakdown; Will/Funeral Arrangements; High Risk for Falls, Self-Determinations/Dignity; Alteration in Emotional Functioning; and Spiritual Concerns. The disciplines that would provide the interventions for these entries were identified as Hospice staff.			

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	One Hospice Care Plan entry addressed a problem "Integration of Nursing Home/ALF [Assisted Living Facility] and Hospice POC [Plan of Care]." The interventions were listed as: "Hospice Plan of Care will be communicated to nursing home within 24 hours of implementation; Instruct and collaborate with nursing home staff regarding roles and responsibilities related to the Hospice POC; Hospice staff will attend nursing home plan of care meetings to integrate information; Hospice staff assigned: RN 2-3/ 14 days, HA 2/week; DME [durable medical equipment] provided by Hospice: none at this time." A coordinated list of specific responsibilities, duties, and services to be provided to the resident by each of the facility and Hospice disciplines was not listed. On 10/17/12, the Executive Director provided a copy of the contract the facility had with the Hospice agency utilized by Resident #63. The contract included, but was not limited to, the following information: "Definitions: (i) Plan of Care... Hospice and Facility will jointly develop and agree upon a			

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	coordinated, interdisciplinary Plan of Care which is consistent with the hospice philosophy and is responsive to the unique needs of Hospice Patient.... Hospice and Facility shall periodically conduct joint reviews of each Plan of Care as necessary to coordinate provision of Facility Services.... 2. Responsibilities of Facility. (e)(ii) Design of Plan of Care. In accordance with applicable federal and state laws and regulations, Facility shall coordinate with Hospice in developing a Plan of Care for each Hospice Patient.... 3. Responsibilities of Hospice. (ii) Plan of Care. (b) Provision of Plan of Care to Facility: Upon a Hospice Patient's admission to Facility, Hospice shall furnish a copy of the current Plan of Care. Hospice shall specify the Facility Services to be furnished by Facility to such Hospice Patient... (iii) Coordination and Evaluation. Hospice shall retain responsibility for coordinating, evaluating and administering the hospice program, as well as ensuring the continuity of care of Hospice Patients, which shall include coordination of Facility Services...." B.2. The clinical record review for			

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	Resident #26 was completed on 10/16/12 at 1 P.M. Diagnoses included, but were not limited to, end-stage dementia, aphasia/dysphagia. Resident #26 had a change in condition on 9/13/12 and was admitted to hospice on 9/15/12. The facility had a care plan for Hospice. The plan did not indicate who was providing services for pain, who was providing feeding assistance, who was providing ADL assistance and when these services were to be provided. It also did not give any frequency regarding how often resident received Hospice services. In an interview during the daily conference on 10/17/12 at 4:15 P.M., R.N. #10 indicated nursing staff had verbal conversations with the Hospice staff when they were in the building. The Hospice nurses for each agency were available by phone as needed. She indicated the facility had no specific service assignments for either facility or Hospice aides related to care, and did not have a list for scheduled visits. 3.1-35(b)(1)			

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F0309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure accurate nursing assessments were completed related to edema to bilateral lower extremities after an ordered medication for edema was not administered for five days (Resident #30), and signs and symptoms of infection at a gastrostomy tube site (Resident #40) resulting in delays in antibiotic treatments. This deficiency affected 2 of 2 residents reviewed for nursing assessments and care in a sample of 15. Findings include: 1. The clinical record for Resident #30 was reviewed on 10/16/12 at 12:45 P.M. Diagnoses for Resident #30 included, but were not limited to, thrombocytopenia, high blood pressure, insomnia, macular degeneration, dysphagia, and muscle	F0309	**F309 Provide Care/Services for highest well being** It is the practice of the provider for each resident to receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #30 was reassessed on 8/16/12 by the physician and no new orders received. Physician was notified on 9/11/12 and family notified on 9/28/12. Resident #40 Physician and Family were notified on 9/27/12 and order for Cipro was initiated. Resident currently does not have signs or symptoms of infection.	11/17/2012

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	weakness. Nursing notes, dated 8/09/12 at 4:30 P.M., indicated ".....Lasix 20 mg. PO (orally), daily....Family notified." The August 2012 Medication Administration Record (MAR) indicated Lasix 20 mg. (milligrams), one (pill), PO (orally), daily for edema, was ordered by the physician on 8/09/12. The August 2012 MAR indicated the medication was not given on 8/09/12, 8/10/12, 8/11/12, 8/12/12, and 8/13/12. The first dose was administered on 8/14/12, as indicated on the MAR. Nursing notes did not indicate any assessment was completed related to not receiving Lasix, 8/9 to 8/13/12. During an interview with the DON on 10/17/12 at 11:00 A.M., she indicated the use for Lasix (diuretic), for Resident #30, was chronic lower extremity edema but, no assessments of the edema were completed by nursing staff. Physician notes, dated 8/16/12, indicated +1 and +2 edema to the lower extremities, equal bilaterally. Physician notes, dated 8/28/12, indicated "Lasix was not given for several days and edema became		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Licensed Staff will be re-educated by the Director of Nursing or designee on the provider's policies regarding order transcription, assessment for edema, assessment for signs and symptoms of infection, documentation of assessments, and notification of next shift and of physician regarding changes of condition. Staff responsible for medication administration will be re-educated regarding the provider's policy regarding unavailable medications. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A Quality of Care Quality Assurance Performance Improvement audit tool will be utilized weekly times 4 weeks, then bi-weekly times 4 weeks, then monthly until alleged deficient practice does not recur. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur,**	

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	worse (at) one point." Nursing notes, dated 9/01/12 at 11:00 A.M., indicated "Residents bilat (bilateral) edema has gotten worse, laid her down in bed to elevate her legs....also c/o (complains of) pain in legs. Both legs are very tight. + (plus sign) pitting edema....will continue to monitor her legs...." On 9/28/12 at 11:00 A.M., nursing notes indicated, "Left foot, 2nd (second) toe very red....tender- + (plus sign) edema whole foot, +3 to +4 edema- call to Dr. (physician name) - Keflex order." Nursing notes, dated 9/28/12 at 9:40 P.M., indicated, "Res (resident) is on ATB (antibiotic) for cellulitis at left foot 2nd (second) toe..." During an interview with the DON on 10/17/12 at 11:00 A.M., she indicated the edema was not properly assessed. During an interview with Resident #30 on 10/18/12 at 2:00 P.M., she indicated she did not know names of medications she received and did not ask because she trusts the nurses to do their job. Additionally, she said she's "had painful swelling to her		**i.e., what quality assurance program will be put into place:** The Quality of Care Quality Assurance Performance Improvement audit tool will be reviewed in the monthly Quality Assurance Performance Improvement meeting by the Quality Assurance committee. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible associate.	

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	lower legs for two, or so, months, approximately. They (legs) were swollen, tight, and painful." 2. The clinical record for Resident #40 was reviewed on 10/15/12 at 1:00 P.M. Diagnoses for Resident #40 included, but were not limited to, osteoporosis, macular degeneration, high blood pressure, atrial fibrillation, chronic heart failure, dysphagia, history of cerebral vascular accident with aphasia, chronic anxiety, left sided pleural effusion, gastroesophageal reflux disorder, failure to thrive and S/P (status post) gastrostomy. Nursing notes on 9/07/12 indicated, "Area around G-tube (gastrostomy tube) site drsg (dressing) when changed has lg. (large) amt. (amount) of greenish slimmy (sic) odorous drainage noted. Passed on to day nurse." During an interview with RN #1, on 10/16/12 at 1:05 P.M., she stated "The communication between the night shift nurse and the day shift nurse, on 9/07/12, was not clear. The day shift nurse told her (RN #1) he was not aware of a possible infection around Resident #40's G-tube			

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	(gastrostomy tube) site, on 9/07/12." RN #1 indicated there was a lack in communication between the nurses that resulted in the physician not being notified of a change in condition, thus resulting in a delay in treatment. Physician orders, dated 9/27/12, indicated an antibiotic was ordered, Cipro 250 mg. (milligrams), crush tablet and sprinkle around G-tube site, daily for 7 days. On 9/28/12 at 9:45 A.M., nursing notes further indicated, "Res. (resident) is on ATB (antibiotic) for GI (gastrointestinal) site infection....." Resident #40 received antibiotic (Cipro) treatment for an infection at G-tube site, from 9/28/12 to 10/04/12, as indicated by the September 2012 and October 2012 MAR. During the daily conference on 10/16/12, information related to further assessments of the area around the G-tube was requested. The DON and RN#1 voiced agreement and understanding. As of the exit conference on 10/18/12, this requested information/documentation was not presented.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-37(a)			

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	155505	A. BUILDING 00 B. WING	10/18/2012

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F0312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure staff were utilizing training given by speech therapy to assist in regards to cueing resident for 1 of 6 residents observed whom staff were feeding during a meal observation in the main dining room in a sample of 15. (Resident #13) Findings include: The clinical record review for Resident #13 was completed on 10/17/12 at 3:15 P.M. Diagnoses included, but were not limited to, legal blindness, anxiety, and reflux disease. A physician's order dated 7/18/12, indicated speech therapy was to work with resident three times a week for fourteen days to rule out penetration/aspiration, and determine least restrictive oral diet. The speech therapy notes dated 7/18/12 indicated, " Pt (patient) is	F0312	**F312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS** It is the practice of the provider to ensure residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #13 was seen by Speech language pathologist on 11/8/12 and recommendations for level of assistance needed at meal times and appropriate diet has been updated. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**	11/17/2012

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	demonstrating intermittent s/s (signs and symptoms) of dysphagia (problems with swallowing) as reported by nurse... Pt has documented weight loss...New dx (diagnosis) LLL (left lower lobe) pneumonia...continued wt (weight) loss and recurrent (line through words) pneumonia..." The speech therapy notes dated 7/30/12 indicated, "...little initiation of eating-requires much encouragement and some feeding per staff..." The speech therapy discharge notes for 8/1/12 indicated, "...Caregivers will return demo (demonstration) understanding of pt spec.(specific) safe swallow techniques (sign for with) 90 (sign for percent) acc (accuracy)...given tactile/verbal cueing from caregivers..." A meal observation was done on 10/15/12 at 1:20 P.M. in the main dining room. There was a group of residents sitting at a table. CNA #3 was observed standing over Resident #13. She stabbed the grilled cheese sandwich with a fork and gave the sandwich to Resident #13. CNA #3 also gave pieces of brownie to the resident. At no time did she cue or encourage the resident to eat. In an interview with Speech Therapist		Facility will review resident's quarterly Speech Therapy screenings for residents that need assistance with cueing and meal consumption to monitor that the facility is following Speech Therapy's recommendations. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Licensed nurses and aides were re-educated on cueing and encouraging residents to consume meals. Recommendations for level of assistance needed at meal times and appropriate diet will be updated in CareTracker profile for the residents that need help with assistance with cueing and meal consumption. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** A resident meal cueing Quality Assurance Performance Improvement audit tool will be utilized weekly times 4 weeks, then bi-weekly times 4 weeks, then monthly until the alleged	

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	#15 on 10/18/12 at 5:00 P.M. she indicated the staff had been trained on feeding techniques for Resident #13. 3.1-38(a)(2)(D)		deficient practice does not recur. The Quality Assurance Performance Improvement audit tools will be reviewed in the monthly Quality Assurance Performance Improvement meeting by the Quality Assurance committee.	

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F0314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on record review and interview, the facility failed to provide adequate prevention measures to a resident with a history of healed pressure areas on the feet for 1 of 5 residents reviewed for pressure areas in a sample of 15. (Resident #4) Findings include: The clinical record review for Resident #4 was completed on 10/17/12 at 10 A.M. Diagnoses included, but were not limited to, Alzheimers, with behavior disturbance, and high blood pressure. The 10/2/12 Quarterly MDS (Minimum Data Set) indicated the resident was highly cognitively impaired, needed total assistance for daily living activities, and he had a stage II pressure sore.	F0314	**F314 Treatment/Services to Prevent/Heal Pressure Sores** It is the practice of this provider to ensure a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #4 is presently on a low air-loss mattress and has Podus boots to bilateral lower extremities. The wounds that were located on the resident's bilateral heels have healed. **How other residents having the potential to be affected by the same deficient practice will be**	11/17/2012

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	Resident #4 was sent to wound care clinic on 2/22/12 due to having a clear fluid filled blister on his right heel. The wound progress notes indicated the wound was a stage II and was 3.6 x 5.0 x 0.1. A treatment was started and the wound care nurse recommended a boot. The wound care clinic notes for 3/13/12 indicated the resident's right heel had healed. The documentation did not indicate any new prevention measures were put into place after the right heel area healed on 3/13/12. As of 3/13/12 both heels were intact without any wounds. A physician's orders indicated, on 2/22/12, to apply prevalon boot to right foot at all times. An order dated 5/25/12 indicated "Podus boots on Bilateral Feet at all times (sign for except) shower and dressing (sign for change)." A 6/25/12 physician's order indicated podus boot and heels off in bed. A physician's order dated 9/24/12 indicated to use a LAL (low air loss) mattress. A care plan dated 5/7/12 indicated that podus boots on bilateral feet when in wheelchair...Assess heels		**identified and what corrective action(s) will be taken:** Licensed staff were re-educated on requesting preventative measures for residents at risk for skin integrity issues. Skin assessments of residents are completed weekly by licensed nurses. At risk residents will be addressed during Nutrition at risk meetings weekly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Licensed staff were re-educated on requesting preventative measures for residents at risk for skin integrity issues. Skin assessments of residents are completed weekly by licensed nurses. At risk residents will be addressed during Nutrition at risk meetings weekly. Director of Nursing or designee will audit the Treatment Administration Record daily times 4 weeks, then 3 times per week for one quarter until the alleged deficiency does not recur. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**	

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	frequently to avoid further breakdown. This care plan was discontinued as of 7/10/12. A care plan dated 8/23/12 indicated interventions were: Monitor with skin care... Report to md any alteration in skin such as rash, persitant redness or skin discoloration, open areas...Turn and reposition every 2 hrs (hours) weekly skin assessment, pressure relieving device on bed and chair. An update was done on 9/25/12 to include LAL mattress and Multi podus boots when in bed. There were no new prevention/interventions listed around 7/26/12 when both areas had healed again. Then the resident had pressure ulcers on both feet on 9/24/12. A document titled 'wound evaluation flow sheet indicated the following information regarding pressure areas on Resident #4's heels: 5/6/12 : right heel -6.4 x 4.2 x .4 Stage III .The current prevention interventions were : podus boot 5/6/12 : left heel-5.2 x 2.4 x 0 Unstagable. The current prevention interventions were : podus boot. 7/15/12 : the right heel area had resolved 7/26/12 the left heel area had resolved		A Treatment Administration Record Quality Assurance Performance Improvement audit tool will be completed daily times 4-weeks, then 3 times per week for one quarter until the alleged deficient practice does not recur. The results of the audits will be reviewed by the Quality Assurance Performance Improvement Team during the monthly meeting.	

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	9/24/12 : left heel- unstagable 1.8 x 1.2 x 0. The current prevention interventions were: podus boot, LAL (low air loss mattress and heels off) 9/24/12 : right heel- stage II 3.6 x 2.8 x 0.1. The current prevention interventions were : podus boot, LAL (low air loss mattress and heels off) 10/11/12 : right heel : 3.2 x 3 x 0. The current prevention interventions were : podus boot, LAL (low air loss mattress and heels off) 10/11/12 : left heel : 1.8 x 1.6 x 0. The current prevention interventions were : podus boot, LAL (low air loss mattress and heels off) A request was made on 10/16/12 at 3:30 P.M. regarding pressure prevention measures regarding resident #4. In an interview with RN #13 at the daily conference on 10/18/12 at 5 P.M. she indicated this was all the information on prevention for Resident #4. 3.1-40(a)(2)			

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F0323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the failed failed to secure chemicals in 1 of 1 locked dementia unit. This deficient practice had the potential to affect 14 of 22 residents identified as ambulatory without assistance. Findings include: On 10/16/12 at 9:15 A.M., 3 Purell hand sanitizer wall dispensers were observed in the locked dementia unit. The 2 wall dispensers were located on the wall between resident rooms. The other wall dispenser was located inside the locked dementia unit, near the front entrance where photo albums were kept for resident use. All 3 hand sanitizer wall dispensers were in working order filled with hand sanitizer. The wall dispensers were placed at a level the average size person could reach while standing or in a sitting position in a wheelchair.	F0323	**F323 Free of Accident Hazards/Supervision/Devices** It is the practice of this provider to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The residents of Clare Bridget Dementia Unit had 14 of 22 residents that were ambulatory without assistance and were identified as having the potential to be affected by the alleged deficient practice. The three hand sanitizer dispensers were immediately removed and are no longer in the Clare Bridge Dementia Unit. **How other residents having the potential to be affected by the**	11/17/2012

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	On 10/16/12 at 9:20 A.M., in an interview, the Memory Care Facilitator indicated the hand sanitizer wall dispenser were for the residents' use. On 10/16/12 at 2:00 P.M., the Executive Director indicated the hand sanitizer wall dispensers were removed for the safety of the residents. On 10/17/12 at 10:00 AM., the Executive Director provided an "MSDS [Material Safety Data Sheet]" for the hand sanitizer. The MSDS included, but was not limited to, "Product Name: Purell Instant Hand Sanitizer... Hazards Identification... When used according to instruction, the product applicable to this MSDS is safe and presents no immediate or long-term health hazard. However, abnormal entry routes, such as gross ingestion, may require immediate medical attention..." 3.1-45(a)(1)		**same deficient practice will be identified and what corrective action(s) will be taken:** The three hand sanitizer dispensers were immediately removed and are no longer located on the Clare Bridge Dementia Unit. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The three hand sanitizers were removed from the walls in the Clare Bridge Dementia Unit. This was accomplished immediately when the issue was brought to the provider's attention by the surveyors. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Staff will be re-educated to the location of the hand sanitizer dispensers and to the reasons why the dispensers were removed so that the alleged deficient practice does not recur.	

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F0327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on observation, record review, and interview, the facility failed to monitor the fluid intake to prevent potential dehydration for 1 of 1 resident reviewed for dehydration in a sample of 15. (Resident #26) Findings include: The clinical record review for Resident #26 was completed on 10/16/12 at 1 P.M. Diagnoses included, but were not limited to, end-stage dementia, aphasia/dysphagia. The dietary notes dated 2/27/12 indicated the resident had aspiration risks and was on pudding thickened liquids. The notes dated 8/9/12 indicated the resident was at high risk for dehydration. The care plan dated 8/29/12 indicated the resident had diuretic use with a potential for dehydration and to offer and encourage fluids and foods if not contraindicated. The nurses notes indicated that on	F0327	**F327 Sufficient Fluid Maintain Hydration** It is the practice of the provider to ensure each resident has sufficient fluid intake to maintain proper hydration and health. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #26 Facility will monitor resident's fluid intake daily to address potential risks for dehydration. It is important to note that this resident is on Hospice services and the resident's clinical condition may deteriorate to where dehydration will become unavoidable. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Licensed nurses were re-educated on assessment, notification and documentation regarding hydration status. Residents at risk for impaired hydration status are reviewed and	11/17/2012

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	9/13/12 "call to room secondary to 'not right'-no appetite -responsive to staff-eyes fixed pupils-not following movement-non-reflexive-somelent (sic)-no change while in Dining Room-just stopped eating-food feel out of mouth-normally eats 100%." The transfer notice to the hospital indicated the resident was on honey thickened liquids. The resident went to the hospital and returned with orders to receive hospice assistance. Hospice started seeing the resident on 9/15/12. The nurses notes indicated the daughter requested IV fluids on 9/15/12. A port a cath was inserted on 9/16/12. The physician's orders indicated on 9/15/12 to discontinue the diuretic. The order for 9/16/12 indicated to start intravenous fluids of D5 1/2 NS 500 ml x 1 over 2-4 hours. In an observation on 10/16/12 at 1:30 P.M. the pudding thickened liquids were on the table after the resident was done with the meal. There was a 240 milliliter (ml) glass of thickened clear liquid and an 240 ml glass of red thickened liquid. Both glasses had approximately 80 ml gone. At 1: 50		addressed quarterly and as needed or upon significant change by the Quality Assurance Performance Improvement Team. Physician will be contacted for further interventions as needed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** 4Licensed nurses were re-educated on assessment, notification and documentation regarding hydration status. Residents at risk for impaired hydration status are reviewed and addressed weekly by the Quality Assurance Performance Improvement Team and physician will be contacted for further interventions as needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** A hydration Quality Assurance Performance Improvement audit tool will be completed on at risk residents for dehydration weekly times 4-weeks, then 3 times per week times one quarter until the alleged deficient practice does not recur. The results of the	

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	P.M. the resident was observed in bed with eyes closed. The resident had a 240 ml cup at her bedside table that had no straw and was full. In an observation on 10/17/12 at 10:35 A.M. there was a 240 ml Styrofoam cup with red thickened liquid in it at the bedside table next to the resident. There was approximately 140 ml left in cup. At 1:50 P.M. after the resident had finished the meal, on the dining room table where the resident sits, there was a 240 ml glass of red pudding thickened liquid and a 240 ml glass of clear pudding thickened liquid. The glasses both had plastic wrap on them and the date 10/17/12 was written on the plastic. The resident was observed in her room at 2:05 P.M. in bed with eyes closed. The cup was on the bedside table and same amount was gone. RNA (restorative nursing aide) #12 indicated she wasn't sure what type of fluids the resident was on. She picked up the cup and looked into it and stated it must be nectar thickened liquids. She then asked CNA (certified nursing aide) #11 who said she thought Resident #26 was on nectar thickened. The aides talked amongst themselves and then CNA #7 indicated that the resident		Quality Assurance Performance Improvement audits will be reported to the Quality Assurance Performance Improvement Team.	

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	was on honey thickened liquids. In an interview with RN #13 on 10/17/12 at 2:10 P.M. she indicated the resident was on pudding thickened liquids and that typically residents with thickened liquids do not have fluids at the bedside. She indicated RNA #12 is a restorative aid and may not know the type of fluids the resident is on. She indicated CNA #7 should know as she assists in feeding Resident #26. She stated the KIOSK where the CNA's document have the information pertaining to the type of fluids the resident is on. She stated this is where the CNA/RNA's would get information for their assignment and anything pertaining to care for resident are in the CareTracker. RN #13 could not identify how the cup got at the bedside as she knows her staff date all the cups and this cup was undated. She indicated the hospice aide provides care but was not sure if she gave any fluids. In an interview with RN #13 on 10/18/12 at 4:50 P.M. she indicated she could not identify who had given the resident fluids at the bedside and that they had not been tracking the consumption of fluids for Resident #26 until today in the CareTracker.			

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	3.1-46(b)			

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	155505	A. BUILDING 00 B. WING	10/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

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F0333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure medications were administered, as ordered, by the physician, resulting in increased, painful edema to the resident's bilateral lower extremities. This deficiency affected 1 of 1 resident reviewed for medication errors in a sample of 15. (Resident #30) Findings include: The clinical record for Resident #30 was reviewed on 10/16/12 at 12:45 P.M. Diagnoses for Resident #30 included, but were not limited to, thrombocytopenia, high blood pressure, insomnia, macular degeneration, dysphagia, and muscle weakness. Nursing notes, dated 8/09/12 at 4:30 P.M., indicated ".....Lasix 20 mg. PO (orally), daily, KCl (potassium chloride) 8 mEq (milliequivalent) PO, daily. Family notified." The August 2012 Medication	F0333	**F333 Residents Free Of Significant Med Errors** It is the practice of the provider to ensure the residents are free of any significant medication errors. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #30 has received the ordered Lasix. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Licensed staff were re-educated on order transcription, assessment, documentation and notification by the Director of Nursing or designee. Staff responsible for medication administration will be re-educated regarding the provider's policy regarding missed medications. **What measures will be put into**	11/17/2012

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	Administration Record (MAR) indicated Lasix 20 mg. (milligrams), one (pill), PO (orally), daily for edema, was ordered by the physician on 8/09/12. The August 2012 MAR indicated the medication was not given on 8/09/12, 8/10/12, 8/11/12, 8/12/12, and 8/13/12. The first dose was administered on 8/14/12, as indicated on the MAR. The August 2012 MAR indicated K Cl, 8 mEq, daily, was ordered by the physician on 8/09/12. The August 2012 MAR indicated the medication was not given on 8/09/12, 8/10/12, 8/11/12, 8/12/12, and 8/13/12. The first dose was administered on 8/14/12, as indicated on the MAR. Physician notes, dated 8/16/12, indicated +1 and +2 edema to the lower extremities, equal bilaterally. Physician notes, dated 8/28/12, indicated "Lasix was not given for several days and edema became worse (at) one point." During an interview with RN#1 on 10/17/12 at 4:30 P.M., she indicated she was aware that the Lasix was not given. She said the medication nurse "overlooked" the order for Lasix and an incident report was completed.		**place or what systemic changes will be made to ensure that the deficient practice does not recur:** A Missing Medication Quality Assurance Performance Improvement audit tool will be utilized weekly times 4 weeks, then bi-weekly times 4 weeks, then monthly until the alleged deficient practice does not recur. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** A Missing Medication Quality Assurance Performance Improvement audit tool will be reviewed in the monthly Quality Assurance Performance Improvement meeting by the Quality Assurance Team. Re-education and corrective action will be provided as indicated by the audit tool findings.	

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	A facility incident report, dated 9/06/12, provided by the Administrator on 10/18/12 at 9:00 A.M., included, but was not limited to, the following: "Lasix 20 mg and K Cl 8 mEq was ordered daily on 8/9/2012. On 8/14/2012 Medication nurse that day noted that the medications had not been given. Medications were written on the MAR, however, no times to be given were noted on the MAR. Spoke with Nurse who had passed the meds (medications) to that resident on 8/10 - 8/13 as to why meds were not given. That nurse stated I must have overlooked them." A document titled "Weekly Skin Integrity Review," with an entry dated 9/01/12, indicated "edema bilat (bilateral) legs." On 9/28/12 at 11:00 A.M., nursing notes indicated, "Left foot, 2nd (second) toe very red....tender- + (plus sign) edema whole foot, +3 to +4 edema- call to Dr. (physician name) - Keflex order." Nursing notes, dated 9/28/12 at 9:40 P.M., indicated, "Res (resident) is on ATB (antibiotic) for cellulitis at left foot 2nd (second) toe....."			

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	During an interview with Resident #30 on 10/18/12 at 2:00 P.M., she indicated she did not know names of medications she received and did not ask because she trusts the nurses to do their job. Additionally, she said she's "had painful swelling to her lower legs for two, or so, months, approximately. They (legs) were swollen, tight, and painful." 3.1-48(c)(2)			

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F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to properly store and handle food and failed to ensure proper drying of metal pans and bowls. This deficient practice had the potential to affect 74 residents who consume food prepared in 1 of 1 facility kitchen. Findings include: On 10/15/12 at 10:40 A.M., tour of the kitchen was initiated with Director of Dining. 1. At that time, the following was observed in the walk-in refrigerator: The following items were observed on the shelves of the walk-in refrigerator: A. 1 open bag of spring mix lettuce without an open or use by date. B. 1 open bag of leaf lettuce without a secure seal.	F0371	**F371 Food Procure, Store/Prepare/Serve-Sanitary** It is the practice of the provider to procure food from approved sources by Federal, State or Local authorities and store, prepare, distribute and serve food under sanitary conditions. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The food product in question was either discarded or the food was covered, labeled, and dated. The pots and pans were washed again and sanitized and placed appropriately on the shelves to allow for air drying. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The food product in question was either discarded or the food was covered, labeled, and dated. The pots and pans were washed again and sanitized and placed appropriately on the shelves to allow for air drying. **What measures will be put**	11/17/2012

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	C. 1 tray with 10 custard pies without a preparation or use-by date, open to air. D. 1 tray with 10 brownie squares with whip cream on the side without a preparation or use-by date, open to air. E. 1 tray with 7 cherry turnovers without a preparation or use-by date and 1 of 7 open to air. F. 1 plastic container with 17 raspberry scones without a preparation or use-by date. G. 2 loaves of banana bread without a preparation or use-by date. H. 1 large bowl of chopped celery without a preparation or use-by date. I. 1 open bag of grated parmesan cheese without a use-by or open date. J. An open gallon container of mustard without a use-by or open date. K. An open gallon container of relish without a use-by or open date. L. A 32 ounce jar of capers without a		**into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Dining Services staff will be educated on proper product storage to ensure the food products are covered, labeled, and dated appropriately. In addition, the Dining Services staff will be educated on proper handling of pots and pans after washing to ensure the pots and pans air dry properly before being used again. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** A food storage and dish air dry Quality Assurance Performance Improvement audit tool will be completed by the Director of Dining Services or designee 2 times daily times 1 quarter, then daily times 1 month, then weekly until the alleged deficient practice does not recur.	

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	use-by or open date. M. An open gallon of salsa without a use-by or open date. The following items were observed on a 2 shelf rolling cart that was open to air: N. 2 pans of green bean salad without a preparation or use-by date. O. 1 pan of marinated mushroom salad without a preparation or use-by date. P. 1 pan of spring salad mix without a preparation or use-by date. Q. 1 pan of shredded lettuce without a preparation or use-by date. The following items were located in the walk-in refrigerator inside a closed rolling cart. R. 1 tray with 8 bowls of green pureed [Director of Dining unable to identify] without a preparation or use-by date and open to air. S. 3 trays with 12 plates of strawberry mouse per tray without a preparation or use-by date and open to air.			

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T. 3 trays with 12 plates of brownies per tray without a preparation or use-by date and open to air.

On 10/15/12 at 11:00 A.M., in an interview, the Director of Dining indicated she knew the above items needed to be labeled and covered; however, regarding the dessert items observed uncovered in the rolling cart, she thought those items could be uncovered since the cart had a door.

On 10/16/12 at 9:00 A.M., the Executive Director provided "Labeling" policy and procedure, dated 10/15/12.

The policy and procedure included, but was not limited to, "Policy: All food items must be labeled and dated before storing... All prepared items must have a label with name of item, date prepared, by whom and dates of discard... All refrigerated items must be stored on shelving... Food storage containers will be: with tight-fitting lid or film wrap or foil... labeled with name and date..."

2. On 10/15/12 at 11:05 A.M., during tour of the kitchen with the Director of Dining, multiple metal pans and metal

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	bowls were observed stacked together. Water was observed between each pan and bowl. At that time, in an interview, the Director of Dining indicated she was aware that while drying, nothing should be stacked. On 10/16/12 at 9:00 A.M., the Executive Director provided "Washing and Sanitizing Dishes" policy and procedure, dated 10/15/12. The policy and procedure included, but was not limited to, "Pots, pans, and cooking utensils must be washed and sanitized using appropriate manual washing procedures... Allow pans to air dry on a sanitized drain board..." 3.1-21(i)(3)			

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F0372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. Based on observation and interview, the facility failed to ensure the facility garbage storage area was free of debris to prevent the potential harborage and feeding of pests on the ground of 1 of 1 dumpster area. This deficient practice affected 74 of 74 residents who resided in the facility. Findings include: On 10/16/12 at 2:00 P.M., environmental tour of the facility was initiated with the Executive Director, the Maintenance Director, and the Housekeeping Director. At that time, the facility waste area was observed. The facility had a compact area for facility trash and 1 dumpster located outside the facility. In an interview, at that time, the Executive Director indicated the outside dumpster was only used for recycled paper. However, on the ground around the dumpster, the following debris was observed and	F0372	**F372 Dispose Garbage and Refuse Properly** It is the practice of this provider to dispose of garbage and refuse properly **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The alleged deficient practice had the potential to affect 74 residents and the debris was immediately cleaned when it was brought to the communities' attention by the surveyors. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The alleged deficient practice had the potential to affect 74 residents and the debris was immediately cleaned when it was brought to the communities' attention by the surveyors. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Staff will be re-educated on proper garbage removal and keeping the trash dumpster area clean and free of debris. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur,**	11/17/2012

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	included, but was not limited to, a beer aluminum can, a "V 8 [vegetable drink]" aluminum can, aluminum foil, a plastic fork, stained napkins and a large amount of paper debris [newspaper] all around the dumpster and between the dumpster and building. On 10/17/12 at 9:30 A.M., in an interview, the Executive Director indicated the facility cleaned the area around the dumpster. 3.1-21(i)(5)		**i.e., what quality assurance program will be put into place:** A trash dumpster debris Quality Assurance Performance Improvement audit tool will be completed by the Director of Housekeeping or designee 1 time daily time 1 quarter, then weekly time 1 quarter until the alleged deficient practice does not recur.	

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F0428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.			
	Based on observation, interview, and record review, the facility failed to ensure a time sensitive medication [influenza vaccine] was labeled with an open date in 1 of 1 locked dementia unit. This deficient practice had the potential to affect 22 of 74 residents who resided on the locked dementia unit and who had the potential to receive the influenza vaccine. Findings include: On 10/15/12 at 12:30 P.M., tour of the locked dementia unit medication refrigerator was initiated with Licensed Practical Nurse [LPN] #1. At that time, 1 vial of "Influenza Virus Vaccine 5 milliliters" was observed open without an open date. On 10/15/12 at 12:35 P.M., in an interview, LPN #1 indicated she was aware the vaccine needed an open	F0428	**F428 Drug Regimen Review, Report, Irregular, Act on** It is the practice of the provider to have each resident's drug regimen reviewed at least once a month by a licensed pharmacist. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The alleged deficient practice had the potential to affect 22 residents on the secured Clare Bridge Dementia Unit. The opened vial of influenza vaccine was discarded. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**	11/17/2012

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	date. On 10/16/12 at 9:00 A.M., the Executive Director provided "Packaging and Labeling" policy and procedure, dated 1/1/2005. The policy and procedure included, but was not limited to, "Policy: Medications are packaged and labeled in accordance with facility requirements and state and federal laws... Procedure... Small multidose vials, such as insulin, eye drops, ear drops, etc... The pharmacy label and any appropriate ancillary labels i.e. precautionary and date open stickers are placed on the packaging vial to prevent covering important information on the medication vial..." 3.1-25(k)		The alleged deficient practice had the potential to affect 22 residents on the secured Clare Bridge Dementia Unit. The opened vial of influenza vaccine was discarded. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Licensed staff were re-educated on the facility's policy on storage, labeling, and disposition/return of drugs. The Pharmacist participates in the facility's Quality Assurance Performance Improvement meetings which are held monthly. Medication administration education is provided monthly by the Pharmacy, Director of Nursing, or designee. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** A Medication cart and refrigerator Quality Assurance Performance Improvement audit tool will be completed daily times 1 month, then 3 times per week until the alleged deficient practice does not recur.	

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F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on interview and record review, the facility failed to ensure	F0441	**F441 Infection Control, Prevent Spread, Linens** It is the practice	11/17/2012

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	that a chest X-Ray was completed at or within 6 months prior to admission; and a that an alternative screening for tuberculosis was done at admission, for 1 of 1 resident reviewed who was identified as a "reactor" [having a positive reaction to the PPD-Purified Protein Derivative skin test]; in a sample of 15 residents. [Resident #49] Findings include: In an interview during the initial orientation tour on 10/15/12 at 11:10 A.M., L.P.N. #1 indicated Resident #49 was admitted to the secured/Alzheimer's unit about 1 month ago. She indicated the resident was ambulatory. The clinical record for Resident #49 was reviewed on 10/18/12 at 10:15 A.M. The resident was admitted from another facility on 9/27/12 with diagnoses that included, but were not limited to, Lewy body dementia, Parkinson's disease, depression, and history of urinary tract infections. A chest X-Ray report, dated 2/4/11, indicated the resident had no active disease at that time, with a calcified granuloma in the left lung base.		of the provider to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #49 was admitted on 9/27/2012. The facility completed a Tuberculosis screen and a chest x-ray with negative results. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The community will audit resident medical records to verify that residents have a current Tuberculosis screen or chest x-ray if the resident has had a positive PPD-Purified Protein Derivative. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Licensed staff was re-educated on the admission process requirement that residents have a Tuberculosis screen or chest x-ray if the resident has had a positive PPD-Purified Protein Derivative completed at or within 6 months of admission. **How the corrective action(s) will be**	

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	155505	A. BUILDING 00 B. WING	10/18/2012

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	A "Record of Tests and Immunizations" form, sent from the previous facility and with dates of 2010 and 2011 for flu vaccine, indicated the resident was a "reactor" to the Mantoux [PPD] skin test. A chest X-Ray completed at or within 6 months prior to admission to Robin Run was not found. A tuberculosis screen, completed at the time of admission, was not found. In an interview on 10/18/12 at 4:20 P.M., the interim Director of Nursing indicated there had been a miscommunication with the previous facility. She indicated Robin Run had requested an X-Ray report from them, assuming a current one had been done. They did not realize the date on the report that was sent was for 2/4/11. The interim Director of Nursing indicated a tuberculosis screen was not done for this resident at the time of admission to Robin Run. 3.1-18(c) 3.1-18(g) 3.1-18(i)		**monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** A Tuberculosis/chest x-ray Quality Assurance Performance Improvement audit tool will be completed by the Director of Medical Records or designee weekly times1 quarter, then monthly times 1 quarter until the alleged deficient practice does not recur.	

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. A. Based on interview and record review, the facility failed to have complete and accurate documentation related to behavior interventions attempted, for 1 of 8 residents reviewed who were identified with behaviors; in a sample of 15 residents. [Residents #46] B. Based on interview and record review, the facility failed to record the date of a physician order for a diuretic medication, for 1 resident experiencing increased leg edema; in a sample of 15 residents. [Resident #30] Findings include: A.1. The clinical record review for Resident #46 was completed on	F0514	**F514 Resident Records-Complete/Accurate/Accessible** It is the practice of the provider to maintain clinical records on each resident in accordance with acceptable professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #46 Staff was re-educated on interventions. Resident care plan was updated and reviewed with staff regarding resident specific interventions, documenting in CareTracker the	11/17/2012

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	10/15/12 at 12:50 P.M. Diagnoses included, but were not limited to, dementia, macular degeneration, constipation and arthritis. The staff in the dementia unit track behaviors by documenting on the "Behavior/Intervention Monthly Flow Record" documentation sheets. The directions on the flow sheet indicated, "Enter target behavior in one of the Behavior Sections. Record the number of episodes by shift with initial. Enter the Intervention Code, Outcome Code and side effect codes with initial for each shift." The monthly flow sheets for Resident #46 recorded yelling episodes for the following months: May: 3 on 5/2, 3 on 5/17, 3 on 5/22, 2 on 5/23, and 3 on 5/30. June : 3 on 6/4, 2 on 6/9, 3 on 6/10, 3 on 6/12, 2 on 6/13, and 2 on 6/14. July : 4 on 7/4, 1 on 7/8, and 2 on 7/16. August : 2 on the 4th, 3 on the 5th, 3 on the 9th, September : 2 on 9/2, 1 on 9/5, and 2 on 9/6. All of these entries indicated the behavior of yelling, but did not indicate the intervention, the outcome		outcome of the intervention. Resident #30 Licensed staff were re-educated on order transcription, assessment, documentation and notification by Director of Nursing or designee. Orders are reviewed daily by Director of Nursing or designee. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The Interdisciplinary Team will review residents exhibiting behaviors weekly. In addition, there will be a monthly meeting to review behaviors that were identified during the Interdisciplinary Team weekly review. Care Plans will be updated as needed during the meetings and also resident profiles in CareTracker will be updated. Licensed staff were re-educated on order transcription, assessment, documentation and notification by Director of Nursing or designee. Orders are reviewed daily by Director of Nursing or designee. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	

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	code, or the side effects for each shift. In an interview with RN #13 on 10/16/12 at 3:50 P.M. she indicated the staff are to mark interventions they have done on the monthly behavior flow record. B.1. The clinical record for Resident #30 was reviewed on 10/16/12 at		**practice does not recur:** Staff will be re-educated regarding proper documentation, interventions, outcomes and review of behavior flow sheet. Licensed staff were re-educated on order transcription, assessment, documentation and notification by Director of Nursing or designee. All orders are reviewed daily by Director of Nursing or designee. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** A Medication Administration Record and Treatment Administration Record Quality Assurance Performance Improvement audit tool will be completed daily times 4 weeks, then 3 times per week for one quarter until the alleged deficient practice does not recur. A Behaviors Quality Assurance Performance Improvement audit tool will be completed daily times 4 weeks, then 3 times per week for one quarter until the alleged deficient practice does not recur.	

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	12:45 P.M. Diagnoses for Resident #30 included, but were not limited to, thrombocytopenia, high blood pressure, insomnia, macular degeneration, dysphagia, and muscle weakness. A comprehensive physician's order sheet for telephone orders, (date not documented), indicated the following: 1. Keflex 500 mg PO (orally) TID (three times per day), for 7 (seven) days. 2. CBC (lab order for complete blood count) on Monday. 3. F/U (follow up) with Dr. (physician name) on Tuesday. On 10/17/12 at 10:15 A.M., during an interview with RN #1, she indicated dates that physician orders were taken are expected to be written/documented on the comprehensive physician's order sheet in the designated "date" space. RN #1 did not know why the date was not documented. No documented date could affect knowing when to give a medication, she explained. She confirmed the orders were received via telephone on 9/28/12 because the September 2012 MAR indicated the first dose of Keflex was given at 1:00 P.M. on 9/28/12.			

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